EXHIBIT B

PART 4 OF 5

Emergency Care Under the IBM Dental Plan

If emergency dental treatment is required, contact your dentist. Charges will be considered for reimbursement in accordance with the percentage rates previously described if eligible under your dental option.

WHAT'S COVERED UNDER THE IBM DENTAL PLAN

Generally, dental services (including most oral surgery) are eligible for benefits to the extent that they are necessary and appropriate for dental health and are considered eligible procedures under the IBM Dental Basic and IBM Dental Plus options. To verify coverage and for specific information on any procedure, you should contact a MetLife customer service representative.

All eligible services will be reimbursed by the Plan you are enrolled in at the time the service is completed. These payments apply to eligible services wherever they are performed, such as the dentist's office or the hospital. Please check with your health plan regarding precertification of your hospital stay.

The annual maximum benefit carries over to/from Dental Plus and Dental Basic when plan changes occur during the same calendar year. If you reach your annual maximum benefit under IBM Dental Plus or IBM Dental Basic, no further dental benefits claims will be payable for that year. The annual maximum benefit restarts on January 1st of the following year for services incurred during that same year.

Preventive Treatment

- *Cleanings,* two per calendar year. Additional cleanings may be allowed if deemed medically necessary by the dental plan.
- *Routine oral examinations,* two per calendar year. Additional oral exams may be allowed if deemed medically necessary by the dental plan.
- *X-rays,* one complete full-mouth x-ray series or panoramic x-ray per 36 months.
- *T* lendar year.
- Sealants.

Basic Restorative Treatment

- Amalgam and composite fillings.

Major Restorative Treatment (Dental Plus only)

- General *anesthesia/analgesia,* treatment will be reviewed by MetLife for dental necessity. Coverage may be combined with the benefit for other services rendered on the same day.
- Caps, crowns, inlays and onlays.
- *Replacement of existing crowns,* inlays or onlays, once every five years, unless waived for medical necessity.
- *Endodontic treatment,* including root canals.
- *Extractions,* including anesthesia and routine postoperative care.
- *I* lants and other related services prior to work being done, in order to be eligible for any benefits. You and your dentist will each receive written notification of the benefits available for these services under the IBM Dental Plan.

BENEFIT DETERMINATION GUIDELINES FOR GENERAL ANESTHESIA/IV SEDATION

Benefits may be available, as determined by the dental plan, for general anesthesia/IV sedation when it is performed in conjunction with the following dental procedures:

- The surgical extraction of two or more teeth completed on the same date.
- When three or more standard extractions of teeth are completed on the same date.
- The closure of an oral antral fistula.
- The surgical exposure of an impacted tooth that is to be retained for orthodontic purposes if orthodontics is covered by the Plan.
- When two or more implants are placed and the implants have been approved for benefits.
- When a standard tooth extraction and a surgical tooth extraction are completed on the same date.

There may be occasions where benefits for general anesthesia/IV sedation are available when a patient has unique needs or where there are clinical situations that warrant its use because local anesthesia administration would not suffice. Some examples include:

- Mentally or physically disabled covered individuals.
- Age of patient - up to seven years - unmanageable
- Patient with spastic disease.
- Infection at injection site where local anesthetic would normally be administered.
- Allergy to local anesthesia.
- Failure of local anesthesia to control pain.
- Extent of surgery - complicated surgical procedures that occur in multiple quadrants of the oral cavity on the same date.

- *Periodontal treatment:*
  - Scaling and root planing are limited to eight quadrants per calendar year. The clinical parameters used for rendering a benefit determination, based on submitted documentation, are as follows: pathologic periodontal pocket depth of 4 mm or greater and evidence of the loss of periodontal ligament attachment (bone loss).
  - Osseous surgery up to four quadrants within a 36-month period.
  - Periodontal maintenance) is limited to four per calendar year (this includes adult and child prophylaxis) and is only payable when there is a history of qualifying periodontal therapy, in at least 2 different quadrants.
  - Local chemotherapy agents used in conjunction with non-surgical periodontal therapy (root scaling and planing) are limited to one per tooth, and for a limited number of teeth that have pocket depth between 6 mm and 8 mm and bleed probing, as determined by the Plan's Dentist Consultants.
  - Local chemotherapy agents used in conjunction with periodontal maintenance therapy (post scaling and root planing or osseous surgery) are limited to one per tooth for a limited number of teeth that show increasing pocket depths between 5 mm and 8 mm and have had no chemotherapeutic agent applied for at least the prior 12-month period. Benefits may be available based on review of the clinical documentation by the Plan's Dentist Consultants, when there is a history of completed active periodontal therapy.
- ***Creation of bridgework and dentures, dentures,*** no coverage is available during the first six months following the date of the insertion of the prosthesis; thereafter, no limit.
- ***Relining existing bridgework or dentures,*** coverage is available only after six months following the date of the insertion of the prosthesis; then no limit.

- *Replacement of existing dentures or bridgework.* For treatment to be eligible the following conditions must be met
  - The existing denture or bridgework was installed at least five years prior to its replacement, and the existing denture or bridgework cannot be made serviceable or
  - The replacement is required to replace one or more natural teeth extracted after placement of the original denture/bridge and the appliance cannot be made serviceable or
  - The existing denture or bridgework is temporary and cannot be made permanent, and replacement by a permanent denture/bridge occurs within 12 months from the date of initial installation of the temporary denture/bridge.

  Note: Any dental treatment for dentures or bridgework received under the dental plan options will be treated as if it was received under the IBM Dental Plus option. For example, if a covered individual received dentures or bridgework less than five years ago under the dental plan options and that individual is now covered under the IBM Dental Plus option, new dentures or bridgework may not be replaced until five years have passed unless the existing denture or bridgework cannot be made serviceable. Temporary and interim dentures are not a covered expense.
- *T* (TMJ)-related charges are covered at 50%:
  - X-rays, up to six views
  - TMJ appliance

  TMJ office visits/treatments, up to 10 per year, including eligible services of other providers for associated treatment

You are strongly urged to contact MetLife to be aware of what the IBM Dental Plus option will cover before you or your eligible dependent receive services in conjunction with TMJ. TMJ-related charges not covered under the IBM Dental Plus option may be under medical plan benefits in certain rare circumstances. See "What's Covered Under the medical plan options."

Major Restorative Benefits In Progress When You Retire

If you retire while covered under the IBM Dental Plus option, you and each covered individual will be eligible for 50% reimbursement for major restorative services. If you are retiring and have work in progress, your services will be reimbursed based on the plan you are enrolled in and your employment status (active or retired) at the time the service is completed. You may want to check with MetLife regarding your individual circumstances.

ORTHODONTIC TREATMENT (IBM DENTAL PLUS)

Orthodontic treatment is covered under the IBM Dental Plus option for each eligible covered individual up to a lifetime maximum of $1,500. The administration of the orthodontic benefit differs from that of other dental services. Here's how:

- When submitting a claim for comprehensive orthodontic treatment, it is only necessary to submit the claim once, at the beginning of the active treatment period. However, additional information may be requested periodically to verify that you or your dependent is still receiving active treatment. Payment will be made to you or the dentist, as indicated on the claim form. Don't wait for orthodontia treatment to be completed before submitting claims to MetLife as the claim filing submission deadline applies. For more information, see "How to File a Claim" in the Administrative In-formation section.

- After the active treatment phase has commenced — placement of the bands upon the teeth — 25% of the total orthodontic charge will be considered the banding fee. Benefits will be paid at 50% of the banding fee, or up to the usual and prevailing rate, and will be made upon submission of the claim form.
- After subtracting the banding fee, the remaining charge for eligible services while the bands are on the teeth will be divided by the number of months of treatment that the orthodontist indicates is required. (Charges include necessary appliances, diagnostic casts, x-rays and subsequent monthly visits while the bands are on the teeth.)
- You will receive a monthly reimbursement check equal to 50% of this calculated monthly amount. Payment for active treatment will end when bands are removed, the patient reaches the lifetime orthodontia maximum or if no longer covered by the IBM Dental Plus option, whichever occurs first, and no further reimbursement will be made.
- Reimbursement will be paid in monthly installments over the course of the treatment, thus the full reimbursement will not be received until conclusion of the active treatment has been reached. Monthly benefits will be sent automatically to you or to your dentist, per your designation on the claim form.
- MetLife will confirm treatment periodically.

Automatic payment will cease if you or your covered family member are no longer covered by the IBM Dental Plus option.

Eligible Orthodontic Services

Eligible services considered orthodontic in nature include removable or fixed appliances and minor or intermediate appliances. All orthodontic appliances are included in the $1,500 lifetime maximum. Retainers are not covered as a separate benefit.

Orthodontic Benefits if You Participated in a Former IBM Dental Plan

If an individual covered under IBM Dental Plus commences orthodontic services on or after the effective date of coverage and had previously received orthodontic services under IBM Dental Plan Option A and/or the MetLife PDP Plan, any amount reimbursed to the retiree for orthodontic services while under these dental plan options will be applied to the $1,500 orthodontic lifetime maximum. The covered individual will only be reimbursed at the 50% level up to the remaining balance of the $1,500 maximum.

Orthodontic Benefits in Progress When You Retire (and are not Medicare-eligible)

If you retire while covered under the IBM Dental Plus option (and are not Medicare-eligible), you and each covered individual will be eligible for orthodontia benefits up to the $1,500 lifetime maximum. If you are retiring and have work in progress (and are not Medicare-eligible), your services will be reimbursed based on the plan you are enrolled in and your employment status (active or retired (and not Medicare-eligible)) at the time the service is completed. You may want to check with MetLife regarding your individual circumstances.

WHAT THE IBM DENTAL PLAN OPTIONS DO NOT COVER

- Treatment for accidental injury to sound natural teeth is not covered by MetLife. However, if you are enrolled in the IBM Low, Medium, or High Deductible PPO Plans, IBM EPO, or IBM High Deductible PPO with HSA Plan options, you may be eligible for medical benefits if the health plan determines that accidental injury coverage applies. If you have other coverage through the Cigna DMA, an HMO or the Aetna Medicare Plan (PPO) or Aetna Medicare Plan (HMO), you should inquire about possible coverage under that Plan.
- Charges for cosmetic dental services.
- Charges for educational programs (such as training in plaque control, nutritional g).
- Experimental, investigational or unproven treatment or procedures.
- Incidental dental procedures. An incidental dental procedure is one that is performed at the same time as a more complex primary procedure and requires little additional dental resources, and in the dental industry, generally identified to be part of the primary procedure code.
- When multiple procedures are done on the same tooth on the same day, MetLife will reimburse only for the most complex procedure done for that date of service.
- Nitrous oxide.
- Prescription drugs are not covered under the dental plan options; however, eligible medications prescribed by your dentist may be covered under the IBM medical plan options (IBM Low, Medium, High Deductible PPO, IBM EPO and IBM High Deductible PPO with HSA). If you are enrolled in an HMO, contact your HMO to determine how prescriptions for dental t
- Protective athletic mouth guards.
- The cost of replacing lost or stolen prosthetic devices, including space maintainers.
- Charges for repair or replacement of an orthodontic appliance.
- Retainers are not covered as a separate benefit, but are included under orthodontia services.
- Reimbursement of orthodontic expenses or other courses of treatment for patients whose treatment started before their coverage began is not covered.
- Charges for oral surgery that are determined to be dental in nature, and exceed covered expense, are not eligible for reimbursement under the IBM Medical Plan options.
- Temporary dentures.
- Services not provided or prescribed by a licensed dentist.

COORDINATION OF BENEFITS

If you or an eligible family member has other coverage in addition to Plan coverage, Plan benefits will be coordinated with the other coverage to avoid duplication of payment. When the Plan's responsibility for benefits is secondary to that of the other coverage, the Plan will not pay a benefit for an eligible expense until the other coverage has paid, and the benefit amount which would normally apply will be reduced by the amount the other coverage paid.

In cases of coordination of benefits, if the primary plan benefit issued is equal to or exceeds the scheduled benefit, there will be no payment made by the Plan. See "Coordinating Coverage" in the Administrative Information section for more information.

WHEN COVERAGE ENDS

When a person ceases to be eligible for dental coverage through IBM, continuation coverage can be obtained, in certain circumstances, through the Transitional Medical Program (TMP) for a limited time. See "Transitional Medical Program (TMP)" in the Administrative Information section for more details.

IBM Vision Coverage

IBM Vision Coverage

ABOUT YOUR VISION BENEFITS

If you are eligible, you have two options for vision coverage in which you can enroll: the IBM Vision Plan offered by Anthem Blue View Vision or the EyeMed Discount Card, provided by EyeMed Vision Care.

IBM VISION PLAN ADMINISTRATOR

Anthem Blue View Vision is the administrator of the IBM Vision Plan.

You can reach Anthem Blue View Vision at 855-765-4552

EYEMED DISCOUNT CARD

You can reach EyeMed Vision Care at 855-245-0621.

Who Is Eligible

Retirees who are not Medicare-eligible and their eligible dependents; non-Medicare-eligible dependents of Medicare-eligible retirees (as described in "Eligibility" in the Personal Benefits Program section of this summary plan description) and those enrolled in the Aetna Medicare Plan (PPO) or Aetna Medicare Plan (HMO) are eligible to enroll in the IBM Vision Plan under the IBM Medical and Dental Benefits Plan for Retired Employees. Retirees who are not Medicare-eligible and their eligible dependents and those enrolled in the Aetna Medicare Plan (PPO) or Aetna Medicare Plan (HMO) are eligible to enroll in the EyeMed Discount Card. IBM's dependent eligibility guidelines pertain to all benefit options under the IBM Medical and Dental Benefits Plan for Retired Employees, including vision, and are not subject to any state laws mandating coverage for anyone not included in IBM's list of eligible dependents.

Note that once you reach age 65 or become eligible for Medicare, coverage will be provided through the OneExchange Medicare Exchange, rather than under IBM's group plans. (This does not apply to retirees enrolled in the Aetna Medicare Plan (PPO) or Aetna Medicare Plan (HMO) options. These individuals will still ha lan options for 2014 and 2015 (as long as they choose to remain enrolled in their Aetna plan).)

ID Card

If you enroll in the IBM Vision Plan or the EyeMed Discount Card, you will receive an ID card, which will remain good for as long as you are enrolled in either vision option. New cards will not be sent each year. If your card is lost or damaged, call member services to request a replacement card.

IBM VISION PLAN

The IBM Vision Plan is designed to encourage you to maintain your vision through regular eye examinations and to help you with vision care expenses for required glasses or contact lenses. The routine eye exams covered through the IBM Vision Plan are designed to maintain your visual heath as well as detect heath conditions that could impact your overall health. The routine eye exams through the IBM Vision Plan are not designed to cover the treatment or monitoring of existing health conditions.

Benefits for the IBM Vision Plan are provided by Anthem BlueView Vision through a fully-insured vision policy, which offers coverage for services from both network providers and vision providers who are not in the network.

Enrollment in the IBM Vision Plan provides benefits for eye exams and eyewear both within and outside the Anthem Blue View Vision network.

The EyeMed Discount Card, provided by EyeMed Vision Care®, is available to you and your eligible dependents at no cost. The card provides you with savings of up to 40% on frames, lenses, lens options and contact lenses, and a discount on an annual eye exam at EyeMed Vision Care network provider locations

When Coverage Ends

If an enrolled family member, cease to be eligible for vision coverage through IBM, continuation coverage can be obtained, in certain circumstances, through the Transitional Medical P (TMP) for a limited time. See "Transitional Medical Program (TMP)" in the Administrative Information section for more details.

IBM Benefits Plan for Retired Employees Medicare-Eligible Participants

Coverage for Medicare-Eligible Retirees

Effective January 1, 2014, Medicare-eligible retirees* and their Medicare-eligible dependents** will no longer be eligible for coverage under the Plan.

IBM's medical, prescription drug, dental and vision group coverage for Medicare-eligible retirees and their Medicare-eligible dependents will end after December 31, 2013. (Exception: If you were enrolled in the Aetna Medicare Plan (PPO) or Aetna Medicare Plan (HMO) as of August 1, 2013, you have an opportunity to transition to OneExchange over two years. See "IBM Medical Options for Medicare-Eligible Retirees" on page 76 for more information.)

Important Note: Medicare-eligible retirees* and their Medicare-eligible dependents** who are affected by this change are referred to throughout this SPD as "Medicare-eligible retirees" and "Medicare-eligible dependents".

* The term "retiree" also includes Medicare-eligible individuals who are: surviving spouses; receiving Medical Disability Income Plan (MDIP) benefits or IBM Long-Term Disability (LTD) Plan benefits; eligible for benefits under the Future Health Account (FHA), the Special Retiree Medical Option (SRMO) and Access Only.

** The term "dependent" includes the following Medicare-eligible individuals to the extent they are eligible dependents under the IBM medical plan: your spouse (regardless of gender); your same-gender civil union partner; your same-gender domestic partner; your dependent children.

HEALTH REIMBURSEMENT ARRANGEMENT

IBM will contribute to a new Health Reimbursement Arrangement (HRA) for those Medicare-eligible retirees who are eligible for a subsidy under the Plan, but only if they enroll in individual medical or prescription drug coverage through the OneExchange Medicare exchange (certain exceptions apply). An HRA is a tax-free account that retirees can use to help pay for premiums for coverage and eligible out-of-pocket health care costs, including deductibles, co-pays and coinsurance.

For more information about the HRA, see "Health Reimbursement Arrangement (HRA)" on page 182, "IBM Supplemental Prescription Drug Benefit" on page 184 and "IBM Supplemental Medical Benefit" on page 187.

ENROLLING IN COVERAGE AND ONGOING SUPPORT

All Medicare-eligible retirees and their Medicare-eligible dependents (except for those living outside of the U.S; enrolled in a Kaiser group plan through IBM; or enrolled in an Aetna Medicare Plan (PPO) or Aetna Medicare Plan (HMO) option as of August 1, 2013) can enroll in individual insurance coverage through the OneExchange Medicare Exchange.

For retirees who become Medicare-eligible during the year (due to turning age 65, retiring, or otherwise becoming Medicare-eligible), you must first take steps to enroll in Medicare Parts A and B. You (and your Medicare-eligible dependents) can then enroll in individual insurance coverage through OneExchange. To contact OneExchange directly, call 855-359-7380 (TTY: 711) toll-free, from 8 a.m. to 9 p.m. Eastern Time, Monday through Friday. Or, visit www.medicare.oneexchange.com/ibm.

The process of engaging with OneExchange's benefit advisors and the individual insurance coverage available through the OneEchange Medicare exchange are not part of the Plan.

Important Note: The insurance policies purchased through OneExchange are individual insurance plans, governed by the Centers for Medicare and Medicaid Services and state la lan and are not subject to ERISA.

IBM Benefits Plan for Retired Employees Health Reimbursement Arrangement (HRA), IBM Supplemental Prescription Drug Benefit and IBM Supplemental Medical Benefit

Introduction

Effective January 1, 2014, IBM has established a Health Reimbursement Arrangement ("HRA") for the benefit of certain of its Medicare-eligible retirees who are eligible for subsidized coverage under the Plan, and who enroll in individual medical or prescription drug insurance coverage through the Towers Watson's OneExchange Medicare marketplace. The purpose of the HRA is to reimburse Medicare-eligible retirees for eligible substantiated expenses, such as premiums for coverage, out-of-pocket expenses (i.e., deductibles, copays and coinsurance), and certain eligible health care expenses, which are not otherwise reimbursed. The HRA is intended to qualify as a self-insured medical reimbursement plan for purposes of Sections 105 and 106 of the In ("Code"), as well as a health reimbursement arrangement as defined in IRS Notice 2002-45.

Eligibility for an HRA

RETIREES ELIGIBLE FOR AN HRA

You are eligible for an HRA if you are either:

- A Medicare-eligible retiree (or are receiving benefits under the IBM Medical Disability Income Plan (MDIP) or IBM Long-Term Disability (LTD) Plan) or
- A Medicare-eligible surviving spouse/dependent

and are eligible for subsidized coverage under the Plan.

In either case, you must enroll in individual medical or prescription drug insurance coverage* through the OneExchange Medicare marketplace. (To enroll in coverage through OneExchange, you must be enrolled in Medicare Part A and Part B.)

You are a retiree eligible for a subsidy under the Plan if:

- You retired from IBM prior to July 1, 1999 and, on your last day of employment, you met the following retirement criteria:
  - Completed 30 or more years of IBM service regardless of your age
  - Completed at least 15 years of IBM service and were at least age 55
- Or, as of June 30, 1999, you were within 5 years of meeting any of the following retirement criteria:
  - Completing 30 or more years of IBM service regardless of your age
  - Completing 15 years of IBM service and reaching at least age 55
  - Completing 5 years of IBM service and reaching at least age 62 or
  - Completing at least 1 year of IBM service and reaching at least age 65 and
  - You retired from IBM and, on your last day of employment, you had completed 30 or more years of service regardless of your age, or you had completed at least 15 years of service and reached at least age 55

* Individual medical or prescription drug insurance coverage is defined as a Medicare Advantage plan, a Medicare Supplement plan (also known as a Medigap plan) and/or a Medicare Part D plan.

- You retired from IBM and, on your last day of employment, you were withdrawal-eligible under the IBM Future Health Account (FHA) or
- You are receiving benefits under the IBM Medical Disability Income Plan (MDIP) or IBM Long-Term Disability (LTD) Plan.

You are a surviving spouse/dependent eligible for a subsidy under the Plan if:

- You were a surviving spouse/dependent eligible for an IBM subsidy as of December 31, 2013
- You were not a surviving spouse/dependent eligible for an IBM subsidy as of December 31, 2013, but:
  - You are a surviving spouse/dependent of a retiree who retired from IBM meeting the retirement criteria listed above (other than a retiree who is withdrawal-eligible under the IBM FHA or is an individual receiving MDIP or LTD Plan benefits) and the retiree elected survivor coverage
  - You are the surviving spouse/dependent of a retiree who retired from IBM who is withdrawal-eligible under the FHA.

Special Considerations

The requirement to enroll in individual medical or prescription drug insurance coverage* through the OneExchange Medicare marketplace does not apply if:

- Your coverage under the Plan ends because you're Medicare-eligible (either on December 31, 2013 or the later date that you become Medicare-eligible) and at that time you're enrolled in a Kaiser Permanente plan option under the Plan and you then enroll in individual Kaiser medical or prescription drug insurance coverage
- You are a Medicare-eligible retiree living outside of the United States or in a United States Territory and you are eligible for a subsidy towards the cost of your Plan coverage
- You are a U.S. Veteran as well as a Medicare-eligible retiree who is enrolled in health coverage through TRICARE for Life or eligible to obtain services from the Veterans Administration (VA).

In these circumstances, you will still need to contact OneExchange to activate your HRA.

* Individual medical or prescription drug insurance coverage is defined as a Medicare Advantage plan, a Medicare Supplement plan (also known as a Medigap plan) and/or a Medicare Part D plan.

When You Will Cease Being Eligible for the HRA

You will cease being eligible for the HRA on the earlier of:

- The date you are no longer eligible for benefits under the MDIP or LTD Plan (unless on that date you are otherwise eligible as a retiree)
- The date you are rehired by IBM or any subsidiary of IBM as an active employee (regular or supplemental) and for the duration of your active employment
- The date you cease to be eligible for Medicare (unless your loss of eligibility is due to your living outside of the United States)
- Your date of death
- The date you are no longer enrolled in individual medical or prescription drug insurance coverage through the OneExchange Medicare marketplace (unless you live outside of the United States, are en-rolled in a Kaiser plan or are enrolled in TRICARE for Life or eligible to obtain services from the VA
- The effective date of any amendment terminating your eligibility or
- The date the HRA is terminated.

You may not obtain reimbursement of any eligible expenses incurred after the date your eligibility ceases. Similarly, you may not obtain reimbursement of any eligible expenses incurred prior to the effective date of coverage under the OneExchange Medicare marketplace.

DEPENDENT EXPENSES ELIGIBLE FOR REIMBURSEMENT FROM THE HRA

Your dependents' eligible expenses can be reimbursed through your HRA.

An eligible dependent is anyone you claim as a dependent on your federal tax return, including: your spouse (regardless of sex); your same-gender civil union partner; your same-gender domestic partner; your dependent children.

When Dependent Expenses Will Cease Being Eligible for Reimbursement from the HRA

Your eligible dependents' expenses will cease being eligible for reimbursement under the HRA on the earlier of:

- The date your dependent(s) ceases to be an eligible dependent for any reason
- The date you and your spouse divorce
- The last day of the year of your death, if you have not elected to provide survivor coverage, as described in the "Using Your HRA" section on page 178.
- The effective date of any amendment terminating your dependent(s) eligibility under the HRA
- The date the HRA is terminated
- The date HRA funds are exhausted.

You may submit an eligible expense for reimbursement if it meets the following criteria:

- The expense incurred was for services or supplies received by you or your eligible dependents under the plan on or after its effective date
- The expense has not been reimbursed in any other way from any other source and will not be submitted for future reimbursement
- The expense does not include any amounts that are otherwise payable by plans for which you or your dependents are eligible
- The expense has not been previously tax-advantaged through another source (for example, if you received a premium subsidy for coverage obtained from a public exchange under the Affordable Care Act, the subsidy is not eligible for reimbursement under the HRA).

You are responsible for submitting claims in compliance with these criteria. Claim decisions will be made in accordance with the provisions of the plan. Health care reimbursements are not eligible deductions or credits on your individual tax return.

Your dependent(s) may not obtain reimbursement of any eligible medical expenses incurred after the date their eligibility ceases. Similarly ligible expenses incurred prior to the effective date of coverage with OneExchange.

CONTINUATION OF COVERAGE FROM THE HRA

The HRA is subject to the Consolidated Omnibus Budget Reconciliation Act (COBRA). Eligible participants who experience a COBRA qualifying event will be offered the opportunity to continue their HRA as a COBRA participant at the full COBRA rate. In most cases, the rate will be based on the date of the qualifying event. Qualifying events include for example, the death of a retiree who elected no survivor coverage; a qualifying event will be considered to have occurred when the eligible surviving dependent no longer has access to the deceased retiree's HRA.

RETIREES NOT ELIGIBLE FOR THE HRA

You are not eligible to receive an HRA if any of the following applies:

- You terminated employment with IBM eligible for Access-Only coverage
- You terminated employment with IBM eligible for the Special Retiree Medical Option (SRMO)
- You do not enroll in medical or prescription drug insurance coverage through the OneExchange Medicare marketplace (unless you live outside of the United States, are enrolled in a Kaiser plan, or are enrolled in TRICARE or eligible to receive services through the VA)
- You continue to participate in the Aetna Medicare Plan (HMO) or Aetna Medicare Plan (PPO).

You are not eligible to participate in the Plan unless you are classified by IBM as a former employee or an employee on the Medical Disability Income Plan (MDIP) or the IBM Long-Term Disability (LTD) Plan who satisfies the eligibility requirements, even if you are later determined by a court or governmental agency to be or to have been a former common law employee of IBM.

Using Your HRA

Once you become eligible for an HRA (as defined in the Eligibility see "Eligibility for an HRA" on page 174), OneExchange will set up your individual HRA. Medicare-eligible retirees and their Medicare-eligible dependents will share the HRA, which will be established in the retiree's name.

Note that the HRA is a "notional" account that's tracked for record-keeping purposes only. There are no actual funds held in your name, and the account is not portable. When the time comes to pay benefits on your behalf, the money comes out of the Plan Trust or IBM's operating funds.

IBM'S CONTRIBUTION TO THE HRA

For participants eligible for an HRA (but not eligible for an FHA)

The first day of each plan year, a fixed dolla location will be made to your HRA. The amount of your HRA contribution will vary based on your eligibility (a):

- Those who retired on or before December 31, 1991
- Those who retired on or after January 1, 1992
- Those receiving benefits under the IBM Medical Disability Income Plan (MDIP) or IBM Long-Term Disability (LTD) Plan and
- Surviving spouse/dependent(s) of the retirees listed above.

The amount of the contribution to your HRA is determined each plan year in IBM's sole discretion as sponsor of the Plan. You will receive a Balance Statement from OneExchange each January reflecting the amount of the contribution to your HRA for the upcoming plan year. You can also call OneExchange directly at 855-359-7380 (TTY: 711), or visit www.extendhealth.com/ibm to learn the amount of the contribution to your HRA.

Your HRA will be reduced by the amount of any eligible medical expenses for which you are reimbursed from the HRA during the plan year. At any time, you may receive reimbursement for eligible substantiated expenses up to the amount in your HRA account. Note: you are not permitted to make any contributions to your HRA account.

Any balance in your HRA at the end of the plan year will be forfeited.

The amount contributed to the HRA for retirees who were required to make a survivor coverage election will vary based on their election, as shown here. For details about making a survivor coverage election, see "Using Your HRA" on page 178.

The 2015 HRA amounts are as follows:*

If you...	IBM's HRA contribution if you elected no survivor coverage	IBM's HRA contribution for your spouse/dependents after your death if you elected no survivor	IBM's HRA contribution if you elected survivor coverage	IBM's HRA contribution for your spouse/dependents after your death if you elected survivor coverage
Retired before January 1, 1992	$3,500	$0	$2,600	$1,300
Retired on or after January 1, 1992	$3,000	$0	$2,374	$1,187
Received LTD or MDIP benefits and were eligible for coverage under the Plan as a retiree	$3,000	$0	$2,374	$1,187
Received LTD or MDIP benefits and were not eligible for coverage under the Plan as a retiree	$3,000	$0	N/A	One year of COBRA coverage subsidized by IBM

* If you are required to elect survivor coverage for your HRA, your HRA value won't be reflected online for several weeks.

I *(starting with the month of your coverage effective date).*

For retirees with a Future Health Account (FHA)

If you are eligible for the Future Health Account (FHA), you will not receive a fixed dollar contribution to your HRA each year. Instead, your FHA balance as of January 2014 (a), or the date you retire and become Medicare-eligible if later (after the last premium for IBM health care coverage is paid) will be transferred into your HRA. For example, if you are eligible for an HRA starting January 1, 2014, your FHA balance as of December 31, 2013 will be transferred to your HRA after your December 31, 2013 premium for IBM health care coverage is deducted in January 2014. The funds in your HRA (as a retiree eligible for the FHA) will roll over year to year until they are depleted.

Your HRA Grows With Interest

For retirees eligible for the Future Health Account, your HRA will be credited with interest. The interest will be added to your account on a monthly basis, as long as a balance remains in your account.

The interest rate is fixed each January 1 at the average of the annual interest rates on one-year U.S. Treasury Constant Maturities, during the preceding months of August, September and October, rounded to the nearest 10th of a percent plus 1%.

For Your Survivors (If you are not eligible for an FHA)

When you become eligible for an HRA (whether it's during the initial transition or at a later time), you will receive a form from IBM's administrator of the HRA survivor election option. You will need to indicate on the form whether you elect to provide survivor coverage after your death. If you choose to pro-vide survivor coverage, the amount of your HRA contribution will be adjusted so that your HRA will be available to your surviving spouse or other eligible dependents (see "Using Your HRA" on page 178) after your death.

Every retiree with the opportunity to elect survivor coverage must fill out and submit the survivor coverage election form even if you do not have a spouse/dependent(s)—and return the form by the timeline provided in the correspondence. Your decision is final and irrevocable.

Regardless of your choice, your decision does not affect coverage for your eligible dependents while you are living. Your eligible spouse/dependent(s) can still be covered under the Plan while you are living.

If you elected survivor coverage, and your surviving spouse/dependent is not Medicare-eligible at the time of your death, your surviving spouse/dependent will receive survivor coverage under the Plan for non-Medicare eligible retirees until they become Medicare-eligible or they cease to be eligible under the Plan, whichever occurs first.

If you elected survivor coverage, after your death, your eligible surviving spouse/dependent, who is Medicare-eligible, will receive an HRA contribution. The amount will vary based on the amount of HRA contribution for which you are eligible. The amount of the HRA contribution a surviving spouse receives will be one-half the amount for which the retiree was eligible before the retiree's death. See the table in "Using Your HRA" on page 178 for the HRA contribution amounts.

If You and Your Spouse are Both IBM Retirees

If you and your spouse are both IBM retirees eligible for an HRA, you will each receive an IBM contribution and have separate HRAs while you are both living. Each IBM retiree who is eligible to elect survivor coverage must do so. You cannot elect the survivor option to provide coverage for your spouse, because he/she will receive their own HRA contribution.

If you have one eligible child, only one of you may elect survivor coverage for that child. If you have two or more eligible children, each of you may elect survivor coverage. Keep in mind, your child will only be eligible for an HRA if he or she is Medicare-eligible. Only one of you has to elect survivor coverage for your non-Medicare eligible child(ren) to be covered under the Plan for non-Medicare eligible participants. If you elect such coverage, after you die, your child will be able to be covered under the Plan until he or she is no longer eligible for the Plan (that is, he or she reaches age 19 or up to age 23 if enrolled in school full-time).

Important Notes:

- If you elect survivor coverage and one of your children later becomes Medicare-eligible due to disability and is approved for continued coverage under the Plan, he or she will then be eligible for an HRA with a contribution amount for a surviving dependent.
- Retirees eligible for an FHA do not make a survivor coverage election. Any amounts remaining in your HRA at the time of your death will be able to be used by your eligible dependents (see "Using Your HRA" on page 178).

ELIGIBLE EXPENSES

You can use the amounts in the HRA to reimburse your expenses for:

- All (or a portion of) the monthly premiums for individual Medicare supplemental insurance, such as Medicare Advantage, Medigap and prescription drug plans for you (and your tax-qualified dependents)
- Medicare Part B or D premiums (if any), for you and your Tax-qualified dependents
- Eligible medical and out-of-pocket expenses such as coinsurance, co-payments and deductibles, for you and your tax-qualified dependents
- Dental and/or vision premiums, for you and your tax-qualified dependents
- Any "eligible health care expense."

Some premiums and out-of-pocket expenses may not be eligible for reimbursement through the HRA. Please contact OneExchange to inquire regarding specific expenses.

An "eligible health care expense" is an expense incurred by you or any tax-qualified dependent for health care, as defined in Internal Revenue Code Section 213(d) (generally, expenses related to the diagnosis, care, mitigation, treatment or prevention of disease). Some common examples of eligible expenses include:

- Medications (in reasonable quantities). Note: Medications are considered eligible medical expenses only if they are prescribed by a doctor (without regard to whether the medication is available with-out a prescription) or is an insulin product
- Dental expenses
- Dermatology
- Physical therapy
- Contact lenses or glasses used to correct a vision impairment
- Birth control pills
- Chiropractor treatments
- Hearing aids
- Wheelchairs
- Premiums for medical, prescription drug, dental or vision coverage provided through OneExchange
- Premiums for medical, prescription drug, dental or vision coverage provided outside of OneExchange (as long as you meet the requirements to qualify for an HRA)
- Premiums for long-term care insurance.

Some examples of common items that are not eligible expenses include:

- Baby-sitting and child care
- Long-term care services

Cosmetic surgery or similar procedures (unless the surgery is necessary to correct a deformity arising from a congenital abnormality, accident or disfiguring disease)

- Funeral and burial expenses
- Household and domestic help
- Massage therapy
- Custodial care
- Health club or fitness program dues
- Cosmetics, toiletries, toothpaste, etc.
- Expenses incurred for qualified long-term care services
- Expenses incurred prior to the date that you became eligible for the HRA
- Expenses incurred after the date that you cease to be eligible for the HRA and
- Expenses that have been reimbursed by another plan or for which you plan to seek reimbursement under another administrator of your plan option.

Generally, expenses for health care services and supplies are eligible for reimbursement if they:

- Are for health care
- Considered tax-deductible by the IRS
- Not reimbursable by a benefits plan, an HMO, insurance or any other source and
- Incurred by you, your spouse or eligible dependents during your coverage period.

If you need more information regarding whether an expense is an eligible medical expense, contact Extend Health, the service provider.

Only eligible medical expenses incurred while you are an eligible retiree with an HRA can be reimbursed from your HRA. Similarly, only eligible medical expenses incurred while your eligible dependent remains eligible to be covered under the HRA may be reimbursed from your HRA. Medical expenses are "incurred" when the medical care is provided, not when you or your eligible dependent is billed, charged or pays for services. Thus, an expense that has been paid but not incurred (e.g., pre-payment to a physician) will not be reimbursed until the service or treatment giving rise to the expense has been provided.

REIMBURSEMENT FROM YOUR HRA

You must complete a reimbursement form and mail, fax or submit it online to OneExchange, along with a copy of your insurance premium bill and proof of payment, for other eligible expenses an "Explanation of Benefits" statement (EOB) or, if no EOB is provided, a written statement from the service provider. The written statement from the service provider must contain the following: the name of the patient; the date service or treatment was provided; a description of the service or treatment; and the amount incurred.

You can obtain a reimbursement form online at www.extendhealth.com/ibm or call 855-359-7380 (TTY: 711). Your claim is deemed filed when it is received by OneExchange.

You must submit requests for reimbursement of eligible substantiated expenses to OneExchange no later than June 30 of the year following the calendar year in which the expense was incurred.

If your claim for reimbursement is approved, you will be provided reimbursement as soon as reasonably possible following approval. Claims are paid in the order in which they are received by OneExchange.

Note: Individuals who are Medicare eligible and eligible for a Health Reimbursement Arrangement (HRA), and who are also eligible for the IBM Special Health Assistance Provision (SHAP) should give careful consideration to the order in which you submit claims for reimbursement of your Medicare Part B premium expense.

To make optimal use of the SHAP benefit, we recommend that you first submit your Medicare Part B premium expense to SHAP, then submit the remaining premium balance against the Health Reimbursement Arrangement (H).

Keep in mind that you may not submit the full Part B Premium to both SHAP and your HRA because you are allowed to be reimbursed for the full amount only once. If you submit your Part B Premium to your HRA first, you risk losing eligibility to be reimbursed through your SHAP benefit for any amount your HRA does not pay. Before submitting an expense for an HRA reimbursement, y , and will not be submitted for future reimbursement.

Automatic Premium Reimbursement

Automatic reimbursement allows you to obtain reimbursement for insurance plan premiums without submitting a monthly claim form. If you'd like to take advantage of the convenience of automatic reimbursement, contact OneExchange or visit www.extendhealth.com/ibm.

If Your Claim for Benefits is Denied

For information on what to do if a claim for benefits is denied, see "Legal Information" on page 209.

ACCESS AND MANAGE YOUR HRA ONLINE

Once your HRA is activated, you can access and manage your funding information online. To access or create an online account, go to www.extendhealth.com/ibm and select the *My Account* link. If you're a first time visitor, fill out the required information to create your account. If you're a returning visitor, enter your username and password.

Once you've logged in or created your account, you can:

- Access your funding information, including your current funding allocation, funding frequency, available balance, recent claims and the histories of your claims and allocations. Click on the Funds & Claims section from the main page
- Print a paper claim form. Click on the Funds & Claims section, then the My Resources link in the Quick Links sidebar of the My Dashboard section. Under Administrative Forms, select Reimbursement Ac-count Claim Form
- Find relevant phone numbers, answers to frequently asked questions and links that allow you to file claims or appeals and
- Elect premium automatic reimbursement.

A NOTE ABOUT TAXES AND IMPUTED INCOME

If a retiree uses the HRA to reimburse expenses for a same-gender civil union or domestic partner, IBM will be required to impute income for the value of the same-gender civil union or domestic partner's coverage.

- For retirees eligible for an HRA (but not an HRA that was converted from an FHA), the value of the coverage is based on the HRA amount, divided by the number of people who have the account available for their use.
- For retirees eligible for the FHA, the value of the HRA is actually determined each year based on the average annual use of the FHA across all retirees.

Imputed income will be applied when any expense is paid for your same-gender civil union or domestic partner. For example, if a retiree is reimbursed $100 in expenses for a domestic partner and the HRA amount is $3,000, the amount that will be imputed is $3,000 divided by two (or 50%) or $1,500. Note that imputed income is not based on actual amounts reimbursed for same-gender civil union or domestic partner expenses, but on the value of HRA coverage as determined by tax laws. Imputed Income will be reported annually on an IBM Form W-2.

While there is no federal tax impact for same-gender spouses based upon the June 26, 2013 Defense of Marriage Act ruling, there may be a state tax impact depending on the state laws in which the retiree/same-gender spouse resides.

IBM Supplemental Prescription Drug Benefit

To provide you with additional financial protection against high prescription drug expenses, IBM provides the IBM Supplemental Prescription Drug Benefit (Drug Benefit) under the Plan.

Eligibility

You are eligible for the Drug Benefit if you satisfy all of the following:

- You are enrolled in a Prescription Drug Plan offered through IBM in 2013, or the day before transitioning to the OneExchange Medicare marketplace, if later
- You are enrolled in a Prescription Drug Plan (either through OneExchange or another source) in the current plan year and
- You remain continuously enrolled in a Prescription Drug Plan (either through OneExchange or an-other source).

Additional eligibility criteria are shown in the table below. You are eligible for the Drug Benefit if you meet the requirements above and fall into a category shown below with a "Yes."

If you...	Retirees and surviving dependents eligible for an annual HRA from IBM, and their eligible dependents	FHA retirees, eligible surviving dependents, and their eligible dependents	Access Only retirees, eligible surviving dependents, and their eligible dependents	Individuals eligible for benefits under the MDIP or LTD plan and eligible dependents
Enroll in medical or prescription drug coverage through OneExchange	Yes	Yes	Yes	Yes
Enroll in Kaiser and were a Kaiser member through IBM prior to the transition to Extend Health	Yes	Yes	Yes	Yes
Live outside U.S. and contact OneExchange (but are not enrolled in an IBM health plan option in 2014)	Yes	Yes	Yes	Yes

The Drug Benefit is not available to any retiree or eligible dependent enrolled in an Aetna Medicare Plan PPO or Aetna Medicare Plan HMO through IBM.

WHEN THE DRUG BENEFIT APPLIES

If your or your eligible dependents' eligible prescription drug costs exceed the annual Medicare Part D prescription drug catastrophic level (and the Drug Benefit catastrophic level indicated below) during a calendar year, IBM will provide an additional reimbursement, beyond any HRA funding you may receive. This additional benefit will cover 100% of the actual eligible claim cost incurred through the end of the calendar year by the individual who reaches the Drug Benefit catastrophic level.

For 2014, the Drug Benefit catastrophic level is $100,000 in "total drug cost," which can include deductibles, coinsurance and copays that you pay, as well as payments made by the plan or pharmaceutical manufacturers toward the cost of your prescription drugs. Your Medicare Prescription Drug (Part D) Plan will send you a monthly prescription plan summary statement that will show your total drug cost.

Important Notes:

- Eligible prescription drug expenses are limited to prescription drug expenses incurred on or after the date the catastrophic level is exceeded.
- Medicare pays benefits before any payments are made by IBM's Drug Benefit.
- Prescription drug plan premium payments are not eligible for reimbursement from the IBM Supplemental Prescription Drug Benefit, nor are claims that are reimbursed from any other source.
- All Drug Benefit reimbursements are tax-free to you or your eligible dependents.

HOW THE DRUG BENEFIT WORKS

The following table provides an example using a participant covered by a common Humana Prescription Drug Plan, who takes 300mg of Caprelsa once daily. The retail cost of one refill is $12,000 for a quantity of 30.

(1) Participant pays full cost until he/she meets the deductible (in this case, the deductible is $250);

(2) Initial Coverage: Participant pays applicable copays for his/her prescriptions until the total retail cost of all drugs reaches the Medicare coverage gap ($2,960)

(3) Coverage Gap: Participant is responsible for the full cost of prescriptions until his/her total out-of-pocket costs reach Medicare's Drug Catastrophic Level ($4,700)

(4) Catastrophic Coverage: Participant makes a 5% copay for his/her prescriptions until the Drug Benefit catastrophic level ($100,000) is reached

(5) IBM Drug Benefit: Participant contacts OneExchange to report his/her qualification for the Drug Benefit and submits claims for reimbursement of eligible expenses for the rest of the year.

Month	Coverage Stage(s)	Total Retail Cost	Amount Paid by Insurance	Amount Paid by Participant	Amount Reimburse d by IBM	Total Retail Cost (YTD)
Month 1	Deductible, initial coverage, coverage gap, catastrophic coverage	$12,000	$7,450	$4,550	———	$12,000
Month 2	Catastrophic coverage	$12,000	$11,400	Yes	———	$24,000
Month 3	Catastrophic coverage	$12,000	$11,400	$600	———	$36,000
Month 4	Catastrophic coverage	$12,000	$11,400	$600	———	$48,000
Month 5	Catastrophic coverage	$12,000	$11,400	$600	———	$60,000
Month 6	Catastrophic coverage	$12,000	$11,400	$600	———	$72,000
Month 7	Catastrophic coverage	$12,000	$11,400	$600	———	$84,000
Month 8	Catastrophic coverage	$12,000	$11,400	$600	———	$96,000
Month 9	Catastrophic coverage	$12,000	$11,400	$600	$600	$108,000
Month 10	Catastrophic coverage	$12,000	$11,400	$600	$600	$120,000
Month 11	Catastrophic coverage	$12,000	$11,400	$600	$600	$132,000
Month 12	Catastrophic coverage	$12,000	$11,400	$600	$600	$144,000

Any drugs purchased outside the U.S. must have an exact American Equivalent (AE) in order to be covered under the Drug Benefit. To receive reimbursement under the Drug Benefit, you must provide the AE information.

If your out-of-pocket prescription drug costs reaches the Drug Benefit catastrophic level during 2014, contact OneExchange at 855-359-7380 (TTY: 711), from 8 a.m.to 8 p.m. Eastern Time, Monday through Friday, to request information on accessing these funds. You may submit claims for reimbursement from the IBM Supplemental Prescription Drug Benefit up to 180 days after the end of the calendar year.

IBM Supplemental Medical Benefit

The IBM Supplemental Medical Benefit will be available for private duty nursing and home health care expenses if:

- Medicare (Part A, B or D) reimburses no claims for the service(s) and/or medication(s) after initial claim submission and appeal
- The participant has paid $6,500 for these service(s) and/or medication(s)
- Care must have been covered under an IBM Medical Plan option in 2013 and be continuous from 2013 into 2014 (no cases qualify if the first date of services occurs in 2014) with no break except if the patient is admitted to a hospital or other facility and then is released home with the same care continuing
- The participant is enrolled in a Medicare Supplement Plan (Medigap or Medicare Advantage) and a Prescription Drug Plan

The IBM Plan pays 100% of eligible expenses for the remainder of the plan year after the participant's out-of-pocket costs for these services reaches $6,500. Cases are subject to ongoing medical necessity re-view every 6 months.

Note: The IBM Supplemental Medical Benefit plan will not cover services or medication that has been partially paid by Medicare and/or Medigap/Medicare Advantage plan, or that are covered by Medicare and are beyond limits that Medicare imposes.

IBM Special Care for Children Assistance Plan

IBM Special Care of Children Assistance Plan

ABOUT THE SPECIAL CARE FOR CHILDREN ASSISTANCE PLAN

The IBM Special Care for Children Assistance Plan (SCCAP) is designed to help you meet expenses for certain treatment and therapy outside the scope of the coverage available under the IBM medical and dental plan options for eligible children with mental, physical or developmental disabilities. "Outside the scope of coverage available" is treatment ineligible for any coverage under the IBM medical and dental plan options, or other coverage such as an HMO. Therefore, medical and dental co-pays, co-insurance, deductibles, out-of-network charges, etc. are not eligible under SCCAP. You are eligible for this assistance only after you have received all aid available to you and your child from federal, state and other sources. Each case is individually reviewed to determine eligibility for assistance. If there is a mental health component of your child's developmental diagnosis, it should first be reviewed by the mental health component of your medical plan.

FOR MORE INFORMATION ABOUT THE PLAN

Call the IBM ESC to request a Special Care for Children Assistance Plan brochure and application package, which includes information on the Plan, instructions for completing your application and the required forms.

Upon approval, SCCAP will cover a portion of the eligible charges incurred, up to a $50,000 lifetime maximum benefit, until the last day of the month in which the child turns age 23 or is no longer eligible under the Plan, whichever occurs first.

WHO IS ELIGIBLE

Dependent children, as defined by the IBM Benefits Plan for Retired Employees, are eligible for benefits under the IBM SCCAP. For a definition of dependent children, see "Eligibility" in the About the Personal Benefits Program section. Please note that if your child becomes a ward of the state, the child is no longer considered an eligible dependent, and benefits are not payable.

When Your Child Turns Age 26

Even if a child is eligible for continuous coverage under the IBM Plan beyond the age of 23, the child will not be eligible for benefits under the IBM SCCAP beyond midnight on the last day of the month in which the child's 23rd birthday occurs.

HOW THE PLAN WORKS

Reimbursement under the IBM SCCAP will be determined as follows:

Reimbursement Rates	
Annual Family Deductible*	$150
Separate from the IBM Medical Plan deductible	
Lifetime Maximum	$50,000 per eligible child
Treatment or Service	**Reimbursement**
Day Care or Residential Care Facility	80% of 75% of eligible charges
Outpatient Facility, Clinic or Independent Practitioner	80% of eligible charges
Special Devices	80% of eligible charges

- A $150 annual family deductible is applied after the reimbursement amount is established. Only expenses incurred in the same calendar year can be applied to your annual deductible, and all claims must be approved and received by the health plan by December 31st of the following year.

Outside Assistance

Outside assistance may be available from federal, state or other sources (such as a local school district or county department of social services). Such assistance is generally funded by tax revenues to which both you and the Company contribute. Therefore, the objective of SCCAP is to provide an extra benefit after you have received all other assistance to which you are already entitled.

In applying for such assistance, IBM benefits should not be considered in calculating the amount to be paid by you. Eligible charges will be reimbursed under the IBM SCCAP only if those charges are payable by you irrespective of the existence of this Plan.

The following calculations are used to determine benefit reimbursement when outside assistance is received:

How SCCAP Reimbursement Is Calculated When There's Outside Assistance

Treatment	Reimbursement Calculation
Clinic and Outpatient Services Reimbursed at 80% of eligible charges	Eligible charges minus the amount of outside assistance received
Day and Residential Special Facilities Care Reimbursed at 80% of 75% of eligible charges	▪ If outside assistance equals or exceeds the initial 25% reduction: ▪ Eligible charges minus the amount of outside assistance received, and the 25% reduction will not be applied ▪ If outside assistance is less than the initial 25% reduction: ▪ Outside assistance will not be used in the reimbursement calculation, and the initial 25% reduction will be applied to the entire amount of eligible charges

WHAT IS COVERED UNDER THE PLAN

Eligible Treatment Facilities

Eligible treatment facilities may include licensed clinics, day or residential special care facilities, special education facilities for the learning disabled child and camps (where the program offered is medically oriented and is part of the child's continued treatment for mental, physical or developmental disabilities).In order to be eligible for reimbursement, the care must be determined to be appropriate and the facility must meet both "A" and "B" and either "C" or "D" below:

(6) Is medically oriented and operated under the supervision of a physician, psychiatrist or licensed Ph.D. clinical psychologist primarily for the rehabilitation or remediation of the child's condition of mental, physical or developmental disability.

(7) Has a planned program for the rehabilitation or remediation of such mental, physical or developmental disability which has been reviewed and approved and is supervised by a physician, psychiatrist or licensed Ph.D. clinical psychologist.

(8) Has the approval of or meets minimum standards of applicable professional associations (for example, American Medical Association, American Psychiatric Association).

(9) Is licensed or certified by or has the specific approval of applicable governmental agencies (for example, state or federal departments of health and/or mental h).

NOTE: If a facility's program is not under the direct supervision of a physician, psychiatrist or clinical psychologist, t 's physician or psychiatrist must continue to be involved with the supervision of the child's treatment and review the child's progress on a regular basis. For a school to be eligible, the school must offer a bona fide learning disability program.

Independent Practitioners and Eligible Conditions

Charges for necessary care and treatment by an independent practitioner will be considered for reimbursement when the practitioner is licensed or certified to practice in his or her particular field. The following are examples of some typical practitioners whose services are eligible under the Plan along with some typical conditions they may treat:

- Independent speech pathologist or audiologist who holds a certificate of clinical competence in speech-language pathology or audiology from the American Speech-Language-Hearing Association and/or licensed by the state to practice speech-language pathology or audiology. Typical conditions requiring treatment from a speech pathologist or audiologist are speech impairments, articulation disorders, myofunctional disabilities and tongue thrust associated with orthodontia.
- Nutritionists or dietitians who are certified as Registered Dietitians (RD) by the American Dietetic Association. Typical conditions requiring treatment from a nutritionist or dietitian are eating disorders such as anorexia nervosa and bulimia nervosa.
- Registered physical or occupational therapists. Typical conditions requiring treatment from a registered physical or occupational therapist are cerebral palsy and other related neuromuscular disorders with functional impairment or "developmental delay."
- Treatment by an orthodontist, when the orthodontia is part of an overall treatment program which includes the surgical correction of orthognatic or orofacial abnormalities.
- Treatment by an optometrist for visual impairments, where the condition is diagnosed as progressive myopia.
- Treatment for a diagnosed learning disability when rendered by a learning disability specialist. The practitioner must have a degree in education, hold a state license or certification to teach, with a background in special education and working with special needs children for a minimum of five years or have a master's degree in special education and hold a state license or certification to teach.
- Academic tutoring is not eligible for coverage under the Plan. Therefore, in order to make a distinction between a bona fide learning disability of a slow learner who may require academic tutoring, it is a requirement of the Plan that the child undergoes psychological or psych-educational testing to support the learning disability condition. The results of this evaluation must be submitted as part of the Special Care application before any treatment program can be approved for benefits.
  - The psychological testing must be administered by an independent psychiatrist, psychologist or school psychologist who is not affiliated with the provider of services.
  - Approved cases require periodic psychological or psycho-educational testing every three years to evaluate the necessity for continuance of coverage.
  - Charges for the psychological testing are eligible for benefits under the Plan if the reason for the testing is to determine whether a learning disability exists, regardless of the test results. If the reason for the psychological testing is other than to ascertain whether the child is learning disabled, charges may be eligible for benefits under the Managed Mental Health Care Program under the IBM Plan or any other health coverage you may have.

Note: Claims for psychological testing must first be submitted to the Managed Mental Health Care Program to determine if any changes are eligible under this program. Charges not eligible under the Managed Mental Health Care Program that are determined to be related to a learning disability can then be considered under SCCAP. SCCAP will not reimburse the difference between in-network and out-of-network charges deemed to be eligible under the Managed Mental Health Care Program.

Note: Holistic, homeopathic and naturopathic treatments are not eligible under the SCCAP. Wilderness Programs are also not eligible for reimbursement under the SCAAP or the IBM Plan

Special Devices

Special devices will be considered for eligibility under the Plan only if the devices are:

- Prescribed by a physician and
- Provide either direct medical t ld's condition of mental, physical or developmental disability or the device must improve the life functioning of the child by enhancing the ability to see, communicate or use his or her limbs.

For example, charges for a special vision aid (such as a prism) for severe loss or impairment of sight will be considered for reimbursement if ineligible under the retiree's medical plan option. Charges for correction of nearsightedness, farsightedness or astigmatism are not eligible. (See the "IBM Vision Coverage" section regarding routine examinations for the prescription or fitting of eyeglasses.)

Hearing Aids

Hearing aid devices may be eligible for IBM medical plan coverage as described in the "IBM Medical Coverage" section.

If a hearing aid benefit is not available through the retiree's medical plan, hearing aids are eligible for coverage under SCCAP. Hearing aids will be reimbursed under SCCAP at 80%, after a $150 annual deductible, up to an individual annual maximum of $400, including repairs and batteries.

HOW TO APPLY FOR SPECIAL CARE BENEFITS

1. To apply for Special Care for Children Assistance Plan benefits, contact the ESC and request a SCCAP application package, which includes information on the Plan, instructions for completing your application and the required forms. SCCAP claim forms are available on NetBenefits. You must apply for coverage before submitting any claims.
2. Once you receive the application package, complete, sign and submit the following forms:
   - Statement of Child's Physician, Psychiatrist or Clinical Psychologist -- this form is required. This is sometimes called the doctor's recommendation form.
   - Statement of Independent Practitioner or Special Care Facility -- this form is completed by the independent provider or facility providing the treatment.
3. It may be necessary to provide additional documentation depending on the services being rendered:
   - For remediation for a learning-disabled child a psychological or psycho-educational evaluation must be submitted. These evaluations are considered valid for three years from the date of testing, and reevaluations must be presented for continuation of assistance. Psychological evaluations are employed to assess the cognitive development of children and to determine if a delay in development or a learning disability exists. Some of the tests included in a psychological evaluation are Stanford-Binet Form L-M (S-B), Wechsler Intelligence Scale for Children-Revised (WISC-R), Wechsler Preschool and Primary Scale of Intelligence (WPPSI) and the Bender Visual Motor Gestalt Test and Woodcock-Johnson.

- When service is being rendered by a clinic, day or educational facility, a brochure describing the facility program and services must be provided.
- The license or certificate of clinical competence is required for speech therapists/pathologists or audiologists who are in independent practice.
- A brochure describing the device and its usage is required when applying for special devices.

4. Complete all forms and send them together with any required additional documentation to the ESC at the address listed on the forms in the application package. Incomplete forms or missing information (missing signature, diagnosis, date of service, provider credentials, etc.) will be returned. This will delay the review process.
5. Special Care for Children Assistance Plan benefits are considered on an annual basis. You must reapply for coverage each year.

If approved, you will receive an authorization for benefits. You may submit bills for charges before services are rendered when payment in advance is a requirement of the facility. However, you should not submit bills prior to 30 days from the start date or 30 days prior to the date the fees are due.

Only expenses incurred in the same calendar year can be applied to the annual deductible. All approved claims for benefits and supporting documentation must be received by Anthem Blue Cross and Blue Shield by December 31st of the year after the charges were incurred. It is the employee's responsibility to submit claims to Anthem.

Where advance reimbursement has been made and your child is subsequently withdrawn from the program or where fees are reduced, you must advise the ESC, since you are responsible for any overpayments made.

You have a responsibility to ensure the accuracy and validity of all bills submitted for payment, to pay the providers of service the amount due them on a timely basis and to advise IBM of any discounts or price adjustments made by the providers.

Note: Eligibility of services other than those described above should be discussed with the SCCAP Administrator at the ESC.

CONVERTING YOUR COVERAGE

There is no conversion privilege under the Plan. Individuals who lose eligibility for coverage may purchase equivalent coverage for a time through the Transitional Medical P
(TMP)" in the Administrative Information section or contact the ESC.

STATUS UNDER PATIENT PROTECTION AND AFFORDABLE CARE ACT

IBM continues to consult with the applicable regulatory agencies to evaluate whether the health reform legislation—the Patient Protection and Affordable Care Act (the "Affordable Care Act")—applies to SCCAP. The SCCAP is a separate plan from the other health plans IBM sponsors.

IBM treats SCCAP as a "grandfathered plan" subject to the Affordable Care Act. As permitted by the Affordable Care Act, a grandfathered health plan can preserve certain basic health coverage that was already in effect when the law was enacted. A grandfathered health plan means that the plan may not include certain consumer protections of the Affordable Care Act that apply to other plans, for example, the requirement for the provision of preventive health services without any cost sharing.